1. I give my permission to Dr. (include any assistants)____________________________________________________
to perform the following procedure(s) transesophageal echocardiogram (TEE)__________________________________________
on______________________________________________________________________________(patient’s name)
2. I understand that during the procedure(s) new findings or conditions may appear and require
an additional procedure(s) for proper care.
3. My doctor has discussed with me the items listed below:
   (a) the nature of my condition;
   (b) the nature and purpose of the procedure(s) that I am now authorizing;
   (c) the possible complications and side effects that may result, problems which may be experienced during
       recuperation, and the likelihood of success;
   (d) the benefits to be reasonably expected from the procedure(s);
   (e) the likely result of no treatment; and
   (f) the available alternatives, including the risks and benefits.
   (g) My physician has also explained that, in addition to the specific risks involved in the procedure(s), there are other
       possible risks that accompany any surgical and diagnostic procedure. I acknowledge that neither my physician
       nor anyone else involved in my care has made any guarantees or assurances to me as to the result of the
       procedure(s) that I am now authorizing. __________________________________________________________
4. I know that other clinical staff may help my doctor during the procedure(s).
5. I understand that the procedure(s) may require that I undergo some form of anesthesia, which may have its own risks.
   My doctor or a representative from the department of anesthesiology has informed me of the course of anesthesia
   that is recommended (if any) along with its possible risks and alternatives.
6. Any tissue or specimens taken from my body as a result of the procedure(s) may be examined and disposed of,
   retained, preserved, or used for medical, scientific, or teaching purposes by the hospital.
7. I understand that my procedure(s) may be photographed or videotaped and that observers may be present in the
   room for the purpose of advancing medical care and education.
8. I do not consent to blood and/or blood products as noted on the Blood Transfusion Release Liability form.
9. I understand what my doctor has explained to me and have had all my questions fully answered.
10. Additional comments:_____________________________________________________________________________________________
____________________________________________________________________________________________________________________________________
Having talked with my doctor and having the opportunity to read this form, my signature below acknowledges my consent to
the performance of the procedure(s) described above.

Signature of Patient or Legal Representative_________________________ Date____________ Time________
If Legal Representative, Relationship to Patient______________________________
Witness__________________________________________________________________________________________
Verbal or Telephone Consent
Name of Legal Representative_________________________ Relationship to Patient__________ Date______ Time____
Witness__________________________________________________________________________________________

1. I have explained the risk, benefits, potential complications, and alternatives of the treatment to the patient and have
   answered all questions to the patient’s satisfaction, and he/she has granted consent to proceed.

Physician’s Signature___________ Date________ Time__________

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